Department of Defense

INSTRUCTION

NUMBER XXXX.XX
[Date]

ASD(HA)

SUBJECT: Medical Encounter and Coding at Military Treatment Facilities

References: (a) DoD Instruction 6040.40, "Military Health System Data Quality Management Control Procedures," November 26, 2002
(b) DoD Directive XXXX.XX, "Medical Records Retention and Coding at Military Treatment Facilities," [DATE]

1. PURPOSE

This Instruction establishes policy, assigns responsibilities, and prescribes procedures for the documentation and coding of outpatient and inpatient medical encounters within Department of Defense (DoD) military treatment facilities (MTFs) in accordance with references (a) and (b).

2. APPLICABILITY AND SCOPE

2.1. This Instruction applies to The Office of the Secretary of Defense, the Military Departments, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, Defense Agencies, DoD Field Activities, and all other organizational entities within the Department of Defense (hereafter referred to collectively as "the DoD Components").

2.2. The Coast Guard, under agreement with the Department of Homeland Security, when it is not operating as a Military Service under the Department of the Navy; and the Commissioned Corps of the United States Public Health Service (USPHS) and of the National Oceanic and Atmospheric Administration (NOAA), under agreements with the Department of Health and Human Services (hereafter referred to collectively as "Other Uniformed Services"). The term "Military Services," as used herein, refers to the Army, Navy, Air Force, Marine Corps and Coast Guard; and their respective National Guard and Reserve Components. The term "Uniformed Services" refers to the Army, Navy, Air Force, Marine Corps, the Coast Guard, the Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

3. POLICY

It is DoD policy that all medical encounters within the Military Health System (MHS) must be accurately and promptly documented and coded, adhering to legal and medical coding classification standards as permitted by MHS data collection systems. Successful documentation and coding efforts assist the following MTF operations:

3.1. Continuity of Care: facilitates quality of care and communication among providers.

3.2. Population Health Management: facilitates the assessment and management of health care requirements for the beneficiary population.

3.3. Resource Allocation: aligns medical resources with operations; supports resource sharing agreements.

3.4. Quality Management/Improvement: facilitates health care quality and improvement initiatives by providing evidenced-based practice through evaluation of clinical outcome data; provides health care professionals with documentation for quality assurance, evaluation, and improvement of treatment methods.

3.5. Financial Management: facilitates MTF revenue by supporting its Uniformed Business Office (UBO) with evidence of treatment and justification for reimbursement claims to third party payers.

3.6. Education and Training: supports education and training for MTF staff, students and patients.

3.7. Productivity: increases/improves provider productivity.

3.8. Medical Readiness: assures accurate medical information is documented in records of deployed forces and facilitates pre and post deployment health assessments.

4. RESPONSIBILITIES

4.1. The Assistant Secretary of Defense (Health Affairs) under the Under Secretary of Defense for Personnel and Readiness shall:

4.1.1. Establish overall policy and procedures for management of the MHS medical coding program.

4.1.2. Monitor compliance with this Instruction.

4.1.3. Modify or supplement this Instruction, as needed.

4.1.4 Ensure synchrony with civilian sector in updating annually the code reference for International Classification of Disease 9th Revision (ICD-9-CM), Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS).

4.2. The Secretaries of the Military Departments shall ensure compliance with this Instruction by the Surgeons General of the Military Departments and MTF Commanders.

5. PROCEDURES

5.1. Military Department Surgeons General shall:

5.1.1. Arrange for random and targeted external audits of their MTFs to identify improvement opportunities.

5.1.2. Ensure optimal medical record coding program performance through the monitoring of metrics. As a minimum, metrics will cover timeliness of record completion, availability of records, quality of documentation and accuracy of coding.

5.2. MTF commanders shall:

5.2.1. Ensure a coding compliance plan is available at the MTFs. The plan, at a minimum, should address:

5.2.1.1. Training for administrative and coding personnel. Training will include: systems training (e.g. Composite Health Care System (CHCS), Ambulatory Data Module (ADM)), diagnostic, evaluation and management (E&M), procedural and supplies coding and medical record documentation.

5.2.1.2. Training for clinical staff. Training will include: systems training (e.g. Composite Health Care System (CHCS), Ambulatory Data Module (ADM)), diagnostic, evaluation and management (E&M), procedural and supplies coding and medical record documentation. Training will be documented in the provider/staff training file.

5.2.1.2.1. All MTFs with in-house intern and residency training programs shall incorporate the coding training program into their intern and residency curriculums.

5.2.1.3. Data user training. Training will include understanding coding conventions, why data were collected, how data were collected, correct use of denominators, and limitations of the data. The TRICARE Management Activity (TMA) WISDOM course (Working Information System to Determine Optimal Management) is one training source.

5.2.1.4. Outline an audit plan for evaluating coding compliance in accordance with DoD guidelines. This includes:

5.2.1.4.1. Providing timely feedback to MTF staff (both clinical and administrative) on coding documentation and compliance (e.g. timeliness, accuracy).

5.2.1.4.2. Incorporating metrics from the TMA/Data Quality Management Control Program as directed in reference (a).

5.2.1.4.3. Identifying opportunities for improvement to the Military Departments' Surgeons General Offices through the monthly monitoring of metrics.

5.2.1.4.4. Evaluating coding accuracy and timeliness of both provider and medical coding staff.

5.2.1.4.5. Assessing the timely provision of coded encounters to third party payers for reimbursement determination.

5.2.2. Incorporate external auditors as part of the compliance plan. External auditors include, but are not limited to: contract personnel; Inspector General; Military Department Audit Agencies. An external auditor is defined as "external to the organization."

5.2.3. Assure in-house auditors/trainers and coders have the following coding references (hard copy or electronic) available for coding use:

5.2.3.1. DoD coding guidelines - most recent version

5.2.3.2. International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) - most current edition

5.2.3.3. Current Procedural Terminology (CPT), 4th Edition - most current edition

5.2.3.4. The Coding Clinic for Health Care Common Procedure Coding System (HCPCS)most current edition

5.2.3.5. Medical dictionary

5.2.3.6. Book of common medical abbreviations

5.2.3.7. Physician Desk Reference (PDR)

5.2.3.8. The CPT Assistant

5.2.4. Make available, resources permitting, the following resources:

5.2.4.1. Coding Clinic for ICD-9-CM (American Hospital Association).

5.2.4.2. "Official Guidelines for Coding and Reporting," Coding Clinic for ICD-9-CM, American Hospital Association.

5.2.4.3. Coding assist program/encoder software. A coding compliance editor will reside in CHCS and will include a codefinder. Specific coding guidance is published by the Unified Biostatistical Utility (UBU).

5.2.5. Assure availability of certified coders as advisors/mentors to coding instructors, auditors and clinical staff.

5.2.6. Ensure coding instructors and auditors are current in DoD coding guidance and coding standards in the civilian medical community.

5.2.7. In accordance with medical coding practices, use the following coding standards:

5.2.7.1. 100% of outpatient encounters, other than Ambulatory Procedure Visits (APVS), should be coded within three business days of the encounter.

5.2.7.2. 100% of APVs should be coded within 15 days of the encounter.

5.2.7.3. 100% of inpatient records should be coded within 30 days after discharge.

5.2.7.4. 100% medical record coding accuracy in each coding area. Coding areas are ICD-9-CM diagnosis/factors influencing health/external causes of injury/morphology, ICD-9-CM procedures, CPT E&M, CPT procedures and HCPCS.

5.2.8. Document adherence to coding standards in both military and civilian performance reports.

6. EFFECTIVE DATE

This Instruction is effective immediately. Military Departments are to provide implementing instructions within 90 days of the date of this Instruction.

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